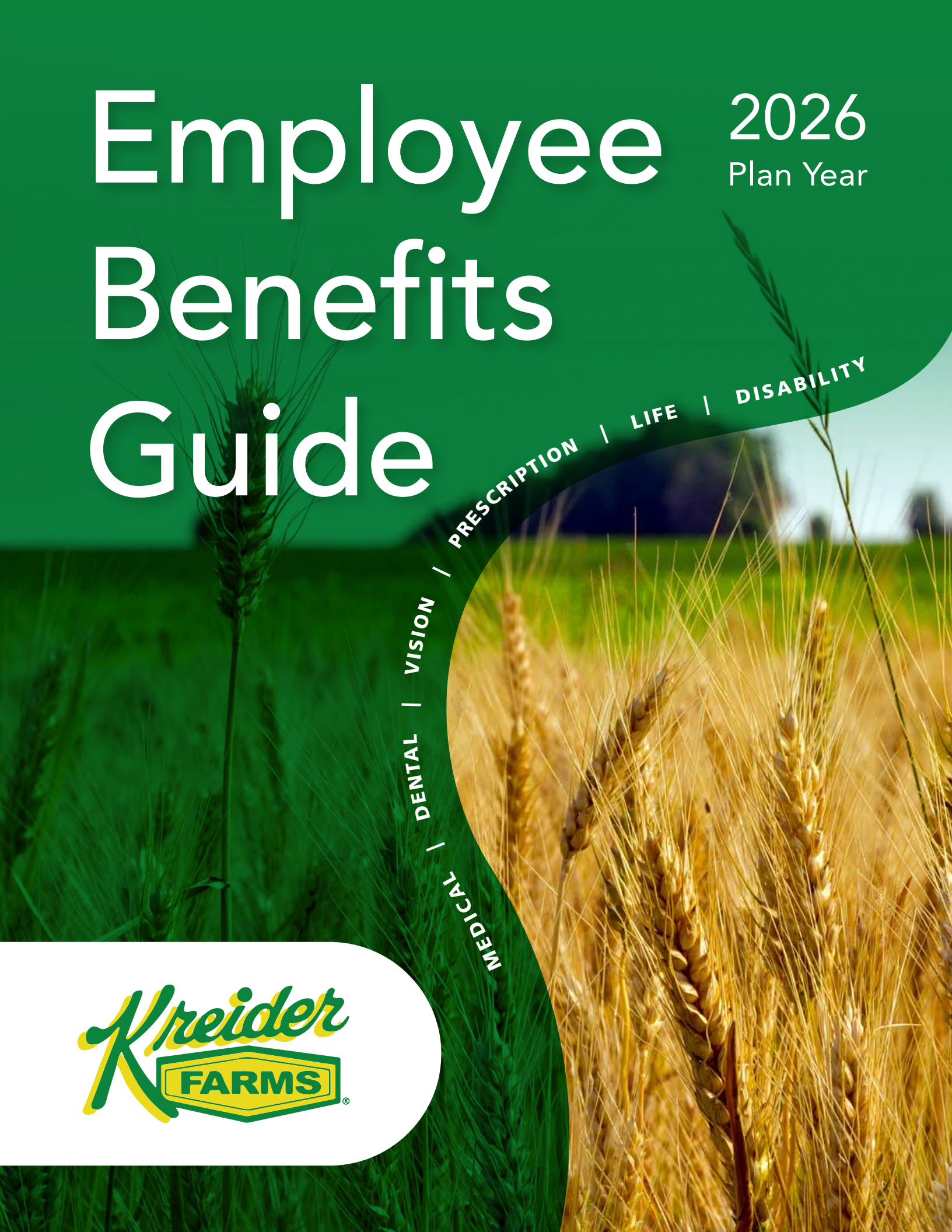
Employee Benefits Guide

2026
Plan Year

MEDICAL | DENTAL | VISION | PRESCRIPTION | LIFE | DISABILITY



Kreider FARMS®

Questions, Problems or Concerns

Our goal is to make certain that you receive the correct coverage under the benefits plan. We are here to help with any issues that may arise. If you require assistance, have your ID number or Social Security Number available and follow these steps:

- **For claims assistance** call the applicable insurance carrier. Have your ID number, date of service, and provider name available.
- If you require further assistance contact AssuredPartners. Kreider Farms has partnered with AssuredPartners as our benefits administrator for expert assistance with benefit related questions, plan procedures, life events and claim issues.
- **Do you need an ID card?** If you do not have an ID card, please contact the insurance carrier to order your ID card or go online to the carrier's site to download an ID card.

Important Contact Information

Carrier	Group #	Web / Email	Phone
Medical and Prescription Capital Blue Cross	00532258	www.capbluecross.com	1-800-962-2242
Health Savings Account Members 1st		www.members1st.org	1-800-237-7288
Dental United Concordia	903316000	www.unitedconcordia.com	1-800-332-0366
Vision Highmark	02540881-82	www.highmarkblueshield.com	1-800-223-4795
Basic Life and AD&D Insurance **Supplemental Life Insurance** Lincoln Financial Group	1306805	www.LincolnFinancial.com	1-800-423-2765
Short-Term Disability **Long-Term Disability** Lincoln Financial Group	1306805	www.LincolnFinancial.com	1-800-423-2765
Hospital Indemnity, Critical Illness, and Accident Insurance Lincoln Financial Group	1306805	www.LincolnFinancial.com	1-800-423-2765
401(k) Retirement Plan PCS Retirement		www.pcsretirement.com	1-888-621-5491
Human Resources Genisee Carranza		genisee.carranza@kreiderfarms.com	1-717-665-8256

New Educational Video Library!

Check out our new educational video library designed to help you navigate the world of insurance with ease. This library features a collection of short, informative videos covering a wide range of insurance-related topics. Dive in and empower yourself with the knowledge to make informed decisions about your benefits!

Find links to individual videos throughout this guide, or check out the full library by clicking this box.

Welcome to your Employee Benefits!

Kreider Farms is pleased to offer a wide range of benefits to its employees and their families. These company sponsored benefits are an important part of a total compensation package. They represent both a valuable asset to our employees and to their families, and demonstrate an investment by Kreider Farms in our employees. We are proud of our compensation benefits program and are committed to continuously improving the plans that make up our benefits offerings.

This guide was created to answer some of the questions you may have about your benefits. Please read it carefully along with any supplemental materials you receive.

If you have any benefits related questions or concerns, please do not hesitate to contact Human Resources.

What's Inside

PLEASE NOTE: This booklet provides a summary of the benefits available, but is not your Summary Plan Description (SPD). Kreider Farms reserves the right to modify, amend, suspend, or terminate any plan at any time, and for any reason without prior notification. The plans described in this book are governed by insurance contracts and plan documents, which are available for examination upon request. We have attempted to make the explanations of the plans in this booklet as accurate as possible. However, should there be a discrepancy between this booklet and the provisions of the insurance contracts or plan documents, the provisions of the insurance contracts or plan documents will govern. In addition, you should not rely on any oral descriptions of these plans, since the written descriptions in the insurance contracts or plan documents will always govern.

How to Enroll At Open Enrollment

NEW BENEFIT

Enroll by Phone

During Open Enrollment, Benefit Counselors are available to assist you with your new elections. They will review your benefits with you on an individual, confidential basis, and will be able to discuss any personal situations you may have that could potentially impact your benefit decisions.

Before you speak with a Benefit Counselor, please have the following information ready: dependents' names, birth dates, social security numbers, addresses, and phone numbers.

Benefits Service Center: 1-855-616-7502 Mon - Fri: 9 am – 8 pm EST | Sat: 10 am – 4 pm EST

ENROLL ON ADP

1 Login

Download the ADP Mobile Solutions app

Enter your **User ID** and **password**, and then click **Sign In.**

If this is your first time logging in and you need assistance, please contact your Human Resources team.

2 Launch Benefits

Click on **"Benefits"** and then click **"Start Enrollment"** to begin. Click Next after reviewing the Welcome Note to move to Manage Dependents. The Manage Dependents page is where you can add/view/edit your dependent and beneficiaries.

3 Enroll

You may notice three sections now to complete your benefit elections. **Action Required, Selected Plans and Eligible Plans.** You cannot complete enrollment unless you take action on any benefits that are listed under Action Required.

4 Confirm Enrollment Selections

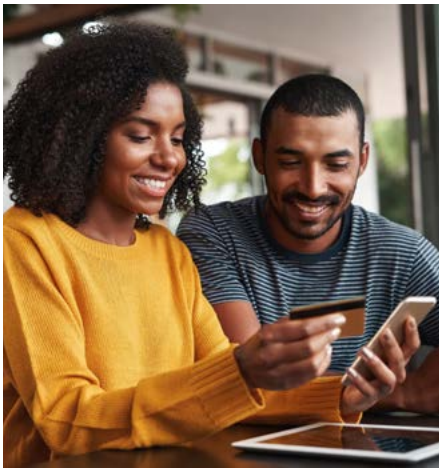
Once enrollment is confirmed it will now display under **Selected Plans.** If you chose to waive a benefit, you will be required to select a **Waive Reason**. Click **Confirm details.** Then click **Confirm** to continue with your enrollment elections. At any time, you can click **"Finish Later"** to save your enrollment information.

Continue through each step until all elections are complete and all tasks under the **Action Required** section are addressed. When ready to proceed to the **Review** and **Submit** step, click **Next**. Your benefit elections will not be processed until you click **Submit** and receive confirmation.

New hires have three options to enroll:

- By Phone (Preferred)
- Mobile App
- Online

We encourage you to download the ADP Mobile App for enrollment. The app is free and available for iOS and Android. Use the QR Code to download the mobile app.



Eligibility

Full-time employees with a regular schedule of **30 hours per week** are eligible for the benefits described in this guide, unless otherwise stated.

When Benefits Become Effective

Coverage for all benefit plans are effective on the first of the month following 60 days after your date of hire. Part-time, seasonal, temporary, internship, and contracted employees are not eligible to participate.

Eligible Dependents

Your dependents are eligible to participate in Kreider Farms' benefit plans. Your eligible dependents include*:

- A spouse to whom you are legally married.
- A dependent child under age 26. Coverage will terminate at the end of the month of the dependent's 26th birthday. Coverage may be extended past the age of 26 for disabled dependents. Dependent children include natural, adopted children, and stepchildren.

Coverage for eligible dependents generally begins on the same day your coverage is effective. Completed enrollment serves as a request for coverage and authorizes any payroll deductions necessary to pay for that coverage.

**Additional carrier conditions may apply and may vary by state.*

Newly Hired/Eligible Employees

New hires and newly eligible employees **MUST** complete enrollment even if choosing to waive coverage in order to provide beneficiary information for your company-paid life insurance.

For all benefits except the 401(k) Retirement Plan, you must enroll within 60 days from your date of hire by going to ADP or by calling 1-855-616-7502.

Pre-Tax Benefits: Section 125

Kreider Farms' benefit plans utilize Section 125. This enables you to elect to pay premiums for health, dental, and vision coverage on a pre-tax basis. When you use pretax dollars, you will reduce your taxable income and have fewer taxes taken out of your paycheck. Under Section 125, you can actually have more spendable income than if the same deductions were taken on an after tax basis.

Pre-tax Note: When you pay for your dependent's benefits on a pre-tax basis you are certifying that the dependent meets the IRS' definition of a dependent. [IRC §§ 152, 21 (b)(1) and 105(b)]. Children/spouses that do not satisfy the IRS' definition will result in a tax liability to you, such as changing that dependent's election to a post-tax election, or receiving imputed income on your W-2 for the dependent's coverage that should not have been taken on a pre-tax basis.

You must notify Human Resources at within 30 days from the life event status change in order to make a change in your benefit selections.

Benefit Changes

The benefit elections you make during open enrollment or as a new hire will remain in effect for the entire plan year. You will not be able to change or revoke your elections once they have been made unless a life event status change occurs.

For purposes of health, dental, and vision you will be deemed to have a life event status change if:

- your marital status changes through marriage, the death of your spouse, divorce, legal separation, or annulment;
- your number of dependents changes through birth, adoption, placement for adoption, or death of a dependent;
- you, your spouse or dependents terminate or begin employment;
- your dependent is no longer eligible due to attainment of age;
- you, your spouse or dependents experience an increase or reduction in hours of employment (including a switch between part-time and full-time employment; strike or lock-out; commencement of or return from an unpaid leave of absence);
- gain or loss of eligibility under a plan offered by your employer or your spouse's employer;
- a change in residence for you, your spouse or your dependent resulting in a gain or loss of eligibility.

In order to be permitted to make a change of election relating to your health, dental, or vision coverage due to a life event status change, the change must result in you, your spouse or dependent gaining or losing eligibility for health, dental or vision coverage under this plan or a plan sponsored by another employer by whom you, your spouse or dependent are employed. The election change must correspond with that gain or loss of eligibility.

You may also be permitted to change your elections for health coverage under the following circumstances:

- a court order requires that your child receive accident or health coverage under this plan or a former spouse's plan;
- you, your spouse or dependent become entitled to Medicare or Medicaid;
- you have a Special Enrollment Right;
- there is a significant change in the cost or coverage for you or your spouse attributable to your spouse's employment.

For purposes of all other benefits under the plan, you will be deemed to have a life event status change if the change is on account of and consistent with a change in status, as determined by the plan administrator, at its discretion, under applicable law and the plan provisions.

Benefit Changes *continued...*

Event	Action Required	Results If Action Not Taken
New Hire:	Make elections within 60 days of hire date. Documentation is required.	You and your dependents are not eligible until the next annual Open Enrollment.
Marriage:	Your new spouse must be added to your elections within 30 days of the marriage date. A copy of the marriage certificate must be presented.	Your spouse is not eligible until the next annual Open Enrollment period.
Divorce:	The former spouse must be removed within 30 days of the divorce. Proof of the divorce will be required. A copy of the divorce decree must be presented.	Benefits are not available for the divorced spouse and will be recouped if paid erroneously.
Birth or adoption of a child:	The new dependent must be enrolled in your elections within 30 days of the birth and adoption, even if you already have family coverage. A copy of the birth certificate, footprints, or hospital discharge papers must be presented. Once you receive the child's Social Security Number, be sure to contact AssuredPartners to update your child's insurance information record.	The new dependent will not be covered on your health insurance until the next annual Open Enrollment period.
Death of a spouse or dependent:	Remove the dependent from your elections within 30 days from the date of death. Death certificate must be presented.	You could pay a higher premium than required and you may be overpaying for coverage.
Your spouse gains or loses employment that provides health benefits:	Add or drop health benefits from your elections within 30 days of the event date. A letter from the employer or insurance company must be presented.	You need to wait until the next annual Open Enrollment period to make any change.
Loss of coverage with a spouse:	Change your elections within 30 days from the loss of coverage. A letter from the employer must be provided.	You will be unable to enroll in the benefits until the next annual Open Enrollment period.
Changing from full-time to part-time employment (without benefits) or from part-time to full-time (with benefits):	Change your elections within 30 days from the employment status change in order to receive COBRA information or to enroll in benefits as a full-time employee. Documentation from the employer must be provided.	Benefits may not be available to you or your dependents if you wait to enroll in COBRA. Full-time employees will have to wait until the annual Open Enrollment period.

If you Experience a Life Event Status Change

Update Your Elections Within 30 Days

You must update your elections within 30 days of your life event status change or you will not be able to make changes until the next annual open enrollment. For assistance processing life event status changes, you can contact Human Resources.

Watch a brief video on changing your elections following life events.

Capital

Medical Coverage

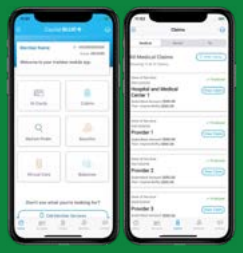
Kreider Farms is proud to offer you medical coverage through Capital Blue Cross. Coverage under the plan includes comprehensive medical care and prescription drug coverage. The plans also offer many resources and tools to help you maintain a healthy lifestyle. Below is a brief description of each plan.

QHDHP 2000 Plan

The Capital Blue Cross HSA Plan is a High Deductible Health Plan, or a HDHP for short. This plan functions like a Preferred Provider Organization (PPO), but features a lower monthly premium in exchange for a higher deductible.

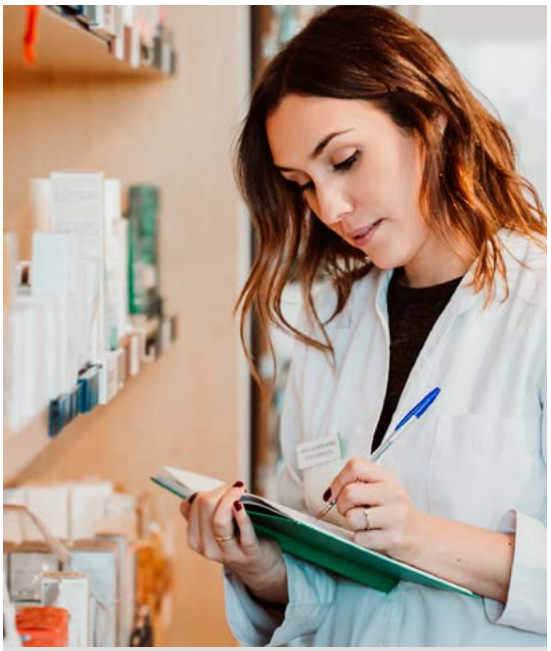
- ✓ Higher deductible to fulfill before plan pays coinsurance
- ✓ Eligible to use Health Savings Account (more info on page 14)
- ✓ Does not require Primary Care Physician (PCP) or specialist referrals
- ✓ Offers out-of-network coverage (although at greater cost to you)

As with a PPO, both you and your family can see any health care provider in the Capital Blue Cross network, including specialists, without a referral. You are not required to choose a primary care physician.



See a doctor anytime, anywhere, with Capital Blue Cross VirtualCare.

We encourage you to download the Capital Blue Cross Mobile App for locating providers, monitoring claims, and more. The app is free and available for iOS and Android. Scan the QR Code to visit the website.



Build a Strong Relationship with Your Primary Care Physician

1. **Personalized Care:** A good relationship allows your PCP to understand your medical history, lifestyle, and preferences, leading to more tailored and effective healthcare.
2. **Trust and Communication:** Trust fosters open communication, making it easier to discuss sensitive issues and follow medical advice.
3. **Preventive Health:** Regular visits and a strong rapport can help in early detection and prevention of health issues.
4. **Coordination of Care:** Your PCP can coordinate with specialists and manage your overall healthcare plan, ensuring continuity and comprehensive care.
5. **Mental Health Support:** A trusted PCP can provide support for mental health concerns, offering guidance and referrals when needed.

Watch a brief video on how High Deductible Health Plans work.

Capital

Medical Plan Comparison

	QHDHP 2000 Plan	
	In-Network, You Pay:	**Out-of-Network, You Pay:**
Deductible (Individual / Family)	**$2,000 / $4,000**	**$2,000 / $4,000**
Out-Of-Pocket Max (Ind / Family)	$2,000 / $4,000 *Deductible Included*	$3,500 / $7,000 *Deductible Included*
Preventive Services Well-Child Care Adult Physical Examination Breast Cancer Screening Pap Test	No charge	No charge
Office Visits	100% after deductible	70% after deductible
Virtual Visits	100% after deductible	70% after deductible
Urgent Care Centers	100% after deductible	70% after deductible
Lab, X-Ray, Diagnostic (non-hospital)	100% after deductible	70% after deductible
Emergency Room Facility	100% after deductible	100% after deductible
Hospital Inpatient	100% after deductible	70% after deductible
Hospital Outpatient	100% after deductible	70% after deductible

This summary is for informational purposes only. For specific benefit information, please refer to the applicable insurance contract.

Plan Cost Per Pay	**QHDHP 2000 Plan**
Employee Only	$75.00
Family	$245.00

Watch a brief video on telehealth.

Capital

Prescription Coverage

Your prescription drug benefit is part of your Medical plan and is based on a three-tier drug system. Copayment and/or coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned as one of the three tiers. Find individualized information on your benefit coverage, determine tier status, check the status of claims and search for network pharmacies by logging on to www.capbluecross.com.

Medicare Part D

The prescription drug benefit is creditable coverage. Medicare-eligible participants need not enroll in a separate Medicare D drug plan.

Rx Mail Order Program

Save time and money by filling maintenance drugs through the mail order program. The Mail Order Program benefits members who are on long-term medications for chronic conditions such as diabetes, high cholesterol, high blood pressure, depression or asthma. By utilizing the Mail Order Program, you can receive a 90-day supply of medication for the equivalent of two retail copayments. That's a savings of one copayment for every 90-day supply. Additional details provided on page 9.

	QHDHP 2000 Plan
Prescription Deductible	**Combined with Medical Deductible**
Retail Copay - up to 31-day supply	
Preventive Drugs	$0.00
Tier 1: Generic	100% after deductible
Tier 2: Preferred Brand	100% after deductible
Tier 3: Non-Preferred Brand	100% after deductible
Mail Order Copay - up to 90-day supply	
Tier 1: Generic	100% after deductible
Tier 2: Preferred Brand	100% after deductible
Tier 3: Non-Preferred Brand	100% after deductible

This summary is for informational purposes only. For specific benefit information, please refer to the applicable insurance contract.

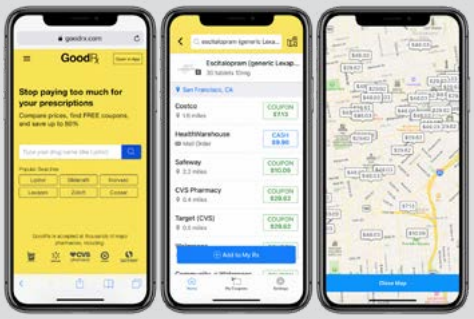
Save money with Generic Drugs

Generic drugs are made with the same active ingredients and produce the same effects in the body as their brand-name equivalents. That's because they're held to the same federal standards for safety and performance as the brand names. Because they're not branded, generics can sell for 30 percent to 80 percent less than their brand-name equivalents.

GoodRx Mobile App

Regardless of which plan you decide to enroll in, we encourage you to download and use the GoodRx Mobile App to help you save on your prescription drug costs. Prices for prescription drugs vary widely between pharmacies. The cost of a prescription may differ by more than $100 between two pharmacies across the street from each other.

GoodRx doesn't sell the medications, they will tell you where you can get the best deal on them. GoodRx will show you prices, coupons, discounts and savings tips for your prescription at pharmacies near you.



Capital

Express Scripts® Pharmacy

Home delivery though Express Scripts® Pharmacy is a safe, convenient way to get your long-term drugs delivered right to your door. It may even help you save money. Plus, Express Scripts® Pharmacy offers:

- 24/7 access to a team of knowledgeable pharmacists and support staff.
- Free standard delivery.
- Tamper-evident, unmarked packaging.
- Refill reminder notices through your phone or email, whichever you prefer.
- Multiple locations across the U.S., for fast processing and dispensing.

It's easy to get started

- Set up an account (including payment information) with Express Scripts® Pharmacy at 1-833-715-0946 or visit https://Express-Scripts.com/rx. You also can log in to your secure account at https://CapitalBlueCross.com and choose Start or Manage Home Delivery.
- Ask your provider to e-prescribe to Express Scripts® Pharmacy or fax your prescription to 1-800-837-0959).
- Continue managing your home delivery service (auto-refills, change in contact information, updated payment information, etc.) through your online account.

Express Scripts® Pharmacy has 30 years of experience helping members get their prescription drugs.

Express Scripts® mobile app makes it easy to manage your prescriptions

- **Refill prescriptions.**
- **Track your order.**
- **Make payments.**
- **Set reminders to take your prescription drugs and more.**

AssuredExcellence™

Low to No Cost Access to Leading National Providers

Kreider Farms has partnered with **the AssuredExcellence program** to connect you and your dependents[1] with ***high quality health care at minimal to no cost.***[2] The program includes benefits for a broad range of services such as:

- Orthopedic Procedures
- Cardiac Surgeries
- Cancer Diagnosis Confirmation Program
- Some Cancer Procedures
- Organ Transplant
- Bariatric Surgery
- Gallbladder Surgery
- Eating Disorder Services
- Hernia Surgery
- Outpatient Mental Health Treatment
- Inpatient Substance Abuse Treatment
- High-Cost Medications
- Pediatric Orthopedics
- Other Treatments are Available

How can I begin the process?

Call the AssuredExcellence team to check eligibility.	Complete an application; provider will review.	Provider will gather and review medical records.	Consultation, surgery, or services are scheduled.	A stipend is paid to you to assist with lodging & transportation.

If you are interested in learning more about the program, checking to see if it includes benefits for the services you need and/or receiving an application, please contact AssuredExcellence at **888-856-4317** or via e-mail at **AssuredExcellence@AssuredPartners.com**.

[1] *Patients must be over age 18 for certain services.*

[2] *Employees enrolled in a high deductible/HSA Qualified Plan will be responsible for the balance required to meet the IRS minimum deductible. There is no patient liability for covered services for all other program participants.*

To ensure that you receive the maximum benefits available you MUST contact the AssuredExcellence team to initiate the process.

1-888-856-4317 | AssuredExcellence@AssuredPartners.com

Participating Partners:

carrum health

Cleveland Clinic

Eating Recovery Center

Pathlight Mood & Anxiety Center

GOLDFINCH Health

Hazelden Betty Ford Foundation

Hoag Orthopedic Institute

JOHNS HOPKINS MEDICINE

MIDLANDS orthopaedics & NEUROSURGERY

MIDWEST ORTHOPAEDICS AT RUSH
A division of OrthoMidwest®

PRICEMDs Cost Containment Solutions™

Shriners Children's™

See back for more details

AssuredExcellence™

Why is this program being offered?

The health and well being of our employees and their families is of paramount importance, and we feel strongly about helping you get care at the best facilities across the country.

How much does it cost?

For most health plans, all treatments at these providers will be at ***NO COST*** to you. Diagnostic procedures required prior to your treatment will go through your regular insurance.

Do I have to travel?

You may, but there are stipends built into the program that are generally enough to cover your travel and more.

Please contact the AssuredExcellence team to discuss any questions or concerns you may have and/or to receive an application to initiate the process.

Procedure Group	Travel Stipend
Bladder Cancer Surgery	up to $3,500
Bone Marrow Transplant	up to $5,500
Cancer Diagnosis Confirmation	up to $1,250
Some Cancer Surgeries (not all types are covered)	up to $3,500
Cardiac/Heart Surgery	up to $3,500
Colorectal Cancer Surgery	up to $3,500
Gall Bladder Surgery	up to $2,500
Organ Transplant	up to $5,500
Lymph Node Surgery	up to $2,500
Neck and Spine Surgery	up to $2,500
Orthopedic Surgery	up to $2,500
Pancreatic Cancer Surgery	up to $3,500
Prostate Cancer Surgery	up to $2,500
Stem Cell Transplant	up to $5,500
Substance Abuse/Rehab	100% of bundled cost
Thyroid Surgery	up to $3,000
RA / PA Medications	Not Needed
Crohns / UC Medications	Not Needed
Multiple Sclerosis Medications	Not Needed
Rare Disorder / Specialty Medications	Up to $1,000 for first fill only
Bariatric Surgery	*If covered by plan, coverage limitations based on your plan apply.*

Travel stipend is determined by the necessary procedure and the AssuredExcellence provider you choose.

To find out what reimbursement you might be eligible to receive, please call AssuredExcellence.

Not every participating provider offers all the AssuredExcellence services. *8.25*

AssuredPartners does not recommend, endorse or make any representation about the efficacy, appropriateness or suitability of any specific tests, products, procedures, treatments, services, opinions, health care providers or other information that may be contained on or available through AssuredExcellence.

AssuredPartners
A Gallagher Company

1-888-856-4317

AssuredExcellence@AssuredPartners.com

AssuredExcellence™

Plan Enhancement!

Specialty Medications at **no cost!**

PRICEMDs
Cost Containment Solutions™

Kreider Farms has partnered with PriceMDs to provide you with a source of specialty medications at no cost!

No travel required, no copays, just free meds!*

Are you currently taking specialty medications for a disease or chronic condition? Examples include medications for crohn's disease, ulcerative colitis, rheumatoid arthritis, multiple sclerosis, or a variety of other conditions.

AssuredExcellence, your source for no-cost surgeries and transplants can now assist in sourcing no-cost medications.

You will receive a stipend payment for your first fill of a 90-day supply!

$1,000 *on medications >$10,000...*

or ***$500*** *on medications $3,000–$9,999...*

or ***$250*** *on medications <$3,000.*

- Over 600 medications available and counting.
- Two fills required before engaging with PriceMDs.
- Members that qualify will be connected with a PriceMDs nurse.
- No change in your physician required!
- You may be required to do a tele-health visit with a US-trained and board-certified doctor.
- PriceMDs may require your doctor to submit lab results, or have you get bloodwork done.
- Once approved the PriceMDs nurse will arrange shipping of 90-day supply of meds direct to you!
- Member participation requires a REAL ID or passport. No travel required.

**If you are enrolled in a Qualified High Deductible Health Plan, you may be subject to charges at the end of the plan year.*

If you're on specialty medications and want to find out if your medication is covered, contact an AssuredExcellence representative today!

(888) 856-4317 AssuredExcellence@AssuredPartners.com

AssuredPartners does not recommend, endorse or make any representation about the efficacy, appropriateness or suitability of any specific tests, products, procedures, treatments, services, opinions, health care providers or other information that may be contained on or available through AssuredExcellence.

AssuredPartners
A Gallagher Company

Where Should I get Medical Care?

If you need emergency care, call 911, or seek help from any doctor or hospital immediately.

When should you go to the emergency room? You should go to the emergency room for life-threatening conditions, severe injuries, sudden severe symptoms, or serious health issues. For less severe issues, consider visiting an urgent care clinic or contacting your primary care physician. It's always better to err on the side of caution when it comes to your health.

Watch a brief video comparing primary care, urgent care, and the ER.

Capital Blue Cross VirtualCare

- Available 24:7, 365 days a year.
- Secure video chat with doctor.
- Download the Capital Blue Cross app to access.

Doctor's Office

- Office hours vary.
- Generally the best place to go for non-emergencies.
- Doctor to patient relationship established; able to treat based on medical history.

Urgent Care Center

- Generally includes evenings, weekends, and holidays.
- Used when your doctor's office is closed, and it's not an emergency.
- Convenient access to medical care.

Hospital Emergency Room (ER)

- Available 24:7, 365 days a year.
- Best option for a medical emergency.
- Highest out-of-pocket cost to you.
- Potentially longer wait times.

Average Cost	Average Cost	Average Cost	Average Cost
$70	$128	$150	$1,374

Industry averages and costs may vary based on the provider you see

MEMBERS 1st FEDERAL CREDIT UNION

Health Savings Accounts

What is an HSA?

A Health Savings Account (HSA) is a tax-advantaged account designed for individuals with high-deductible health plans (HDHPs). Contributions to an HSA can be made by both the employee and the employer, and these funds can be used to pay for qualified medical expenses such as doctor visits, prescriptions, and dental care.

To qualify for an HSA, you must be enrolled in a high-deductible health plan such as Kreider Farms' HSA Plan, have no other health coverage, not be enrolled in Medicare, and not be claimed as a dependent on someone else's tax return.

Save Money on your Taxes!

$100 from your paycheck

	Taxes Paid	Leftover for Medical Expenses
***Without* HSA**	**$30**	**$70**
With HSA	**$0**	**$100**

Key Benefits

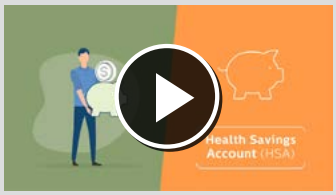
1. **Triple Tax Advantage:** Contributions are made pre-tax, money in the account grows tax-free, and withdrawals for qualified medical expenses are tax-free.
2. **Flexibility:** Unlike Flexible Spending Accounts (FSAs), **HSAs are not "use-it-or-lose-it."** Unused funds roll over year to year and can be invested to grow over time.
3. **Portability:** HSAs are owned by the employee, meaning the account stays with you even if you change jobs or retire.
4. **Contribution Limits: For 2026, the maximum contribution is $4,400 for individuals and $8,750 for families.** Individuals aged 55 and older can make an additional catch-up contribution of $1,000.

What can I use my HSA for?

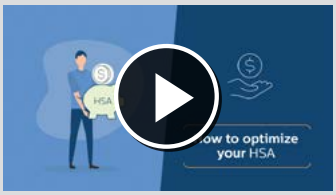
Your Health Savings Account (HSA) can be used to pay for a wide range of qualified medical expenses. Here are some examples of qualified expenses:

- Doctor Visits
- Prescription Medications
- Dental Care
- Vision Care
- Medical Equipment
- Mental Health Services
- Preventive Care
- Over-the-Counter Medications

Using your HSA for these qualified expenses not only helps you manage out-of-pocket healthcare costs but also maximizes the tax benefits associated with the account.



Watch a brief video on Health Savings Accounts (HSAs).



Watch a brief video on how to optimize your HSA.

Note: As a taxpayer, it is your responsibility to ensure that your HSA contributions do not exceed the maximum possible for your specific tax situation. Please consult your attorney, CPA or tax adviser about your specific tax situation before deferring monies to your Health Savings Account. The benefits of an HSA, who is qualified to have an HSA, etc. can be found in IRS Publication 969, beginning on page 2. https://www.irs.gov/pub/irs-pdf/p969.pdf

United Concordia dental℠

Dental Coverage

Find your Provider

The DPPO Plan offers you flexibility to see the provider of your choice each time you seek dental care. You can find a United Concordia network dentist online at www.unitedconcordia.com, or by calling 1-800-332-0366.

	United Concordia DPPO	
	In-Network, You Pay:	**Out-of-Network, You Pay:**
Calendar Year Maximum (Class I, II, III Expenses)	$1,000 per person, per year	$1,000 per person, per year
Calendar Year Deductible Per Individual / Per Family	$25 / $75	$25 / $75
Class I Expenses - Preventive & Diagnostic Care Oral Exams, Cleanings, Routine X-Rays, Fluoride Application	No charge; 100% covered	No charge; 100% covered
Class II Expenses - Basic Restorative Care Fillings, Simple Extractions, Anesthetics, Root Canal Therapy, Repairs (Bridges, Crowns, Inlays and Dentures)	20% after deductible	20% after deductible
Class III Expenses - Major Restorative Care Crowns, Inlays, Onlays, Dentures, Bridges, Stainless Steel/ Resin Crowns	50% after deductible	50% after deductible
Class IV Expenses - Orthodontia Coverage for Eligible Children Only	50% after deductible	50% after deductible
Lifetime Maximum	$1,000	$1,000

This summary is for informational purposes only. For specific benefit information, please refer to the applicable insurance contract.

Plan Cost Per Pay	United Concordia DPPO
Employee Only	$17.50
Employee + 1	$35.00
Family	$52.50

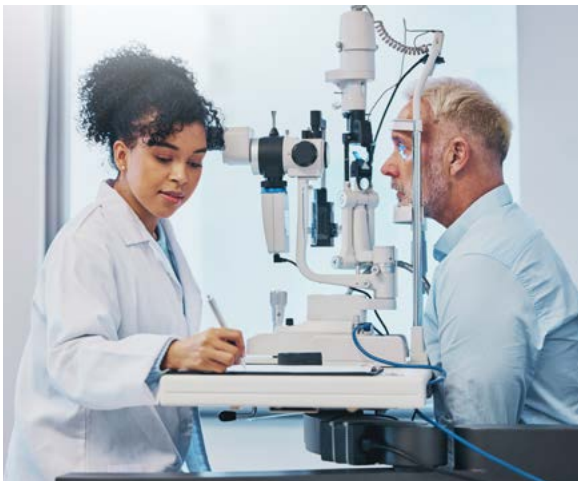
Dental & Vision must be elected together. The rates reflected above are for both dental and vision coverage

Watch a brief video on how to read an Explanation of Benefits (EOB).

Out-of-Network Providers & Balance Billing

*Under the United Concordia DPPO, the plan pays 90% to out-of-network providers as it would for in-network providers. Please note that providers that do not participate with your insurance plan can "balance bill" you for any difference between their charge and what the plan pays. Therefore, using non-participating providers **may result in significant patient liability.**

Vision Coverage



Find your Provider

Choose a Highmark doctor or any other provider from the Highmark Network. To find a Highmark provider, visit www.highmarkblueshield.com or call 1-800-223-4795. At your appointment, tell them you have Highmark. There's no ID card necessary. Highmark will handle the rest—there are no claim forms to complete when you see an in-network provider.

	Highmark Vision Plan In-Network Fashion Advantage VI
Exam Services *Once every 12 months*	$0 copay
Frames *Once every 24 months* Davis Vision Frame Collection Fashion Level Designer Level Premier Level Non-Collection Frame Allowance (Retail):	 Up to $125 Up to $175 Up to $225 Up to $130
Contact Lenses *Once every 12 months* Non-Collection Contact Lenses: Materials Allowance Collection Contact Lenses Medically Necessary	 Up to $85 Covered in full Included
Standard Plastic Lenses *Once every 12 months* Single / Bifocal / Trifocal / Lenticular Oversized Lenses Scratch-Resistant Coating Progressive Lenses: Standard / Premium	 Included Included Included $50-$90

Out-of-Network Provider Coverage:

Visit www.highmarkblueshield.com for details, if you plan to see a provider other than a Highmark network provider.

Exam . . . . . up to $35	Lined Bifocal Lenses . . . . . up to $55	Progressive Lenses . . . . .up to $55
Frame . . . . . up to $70	Lined Trifocal Lenses . . . . . up to $90	Contacts . . . . . .up to $225
Single Vision Lenses . . . . . up to $40		

This summary is for informational purposes only. For specific benefit information, please refer to the applicable insurance contract.

Plan Cost Per Pay	Highmark Vision Plan
Employee Only	$17.50
Employee + 1	$35.00
Family	$52.50

Dental & Vision must be elected together. The rates reflected above are for both dental and vision coverage

Basic Life and AD&D Insurance

Basic Life Insurance

Life insurance provides financial protection for your family in the event of your passing. Kreider Farms offers all eligible employees life and accidental death and dismemberment insurance through Lincoln Financial Group. **Kreider Farms covers the full cost of this benefit.**

Basic Life Benefit Amount: $20,000
AD&D Benefit Amount: Equal to Life amount

Your benefit amount will reduce by 35% at age 65, 55% at age 70, 70% at age 75, 80% at age 80, 85% at age 85, and 90% at age 90.

Plan Cost: 100% Employer Paid

Voluntary Life and AD&D Insurance

Increase Your Coverage

You may elect to increase your life insurance coverage for yourself, your spouse and your dependent children – all at an affordable group rate provided by Lincoln Financial Group. Elect coverage up to the Guaranteed Issue during the initial enrollment period and you will not be required to answer health questions to qualify for coverage. Amounts over the Guaranteed Issue amount will require Evidence of Insurability (EOI).

Employee Voluntary Life/AD&D Insurance

Benefit: increments of $10,000 up to $500,000 or 5x the employee's annual earnings rounded to the next higher $10,000 or $500,000

Guarantee Issue: $200,000

Age Reduction: Age 70: Reduces to 45%
Age 75: Reduces to 30%
Age 80: Reduces to 20%
Age 85: Reduces to 15%
Age 90: Reduces to 10%

Spousal Voluntary Life/AD&D Insurance

Benefit: increments of $5,000 up to $250,000, not to exceed 2.5x annual earnings rounded to the next higher $5,000 or $250,000

Guarantee Issue: $30,000

Benefits Term: When employee reaches age 70

Dependent Child Voluntary Life Insurance

Day 1 to 6 months: $1,000

6 months to 26 years: $20,000

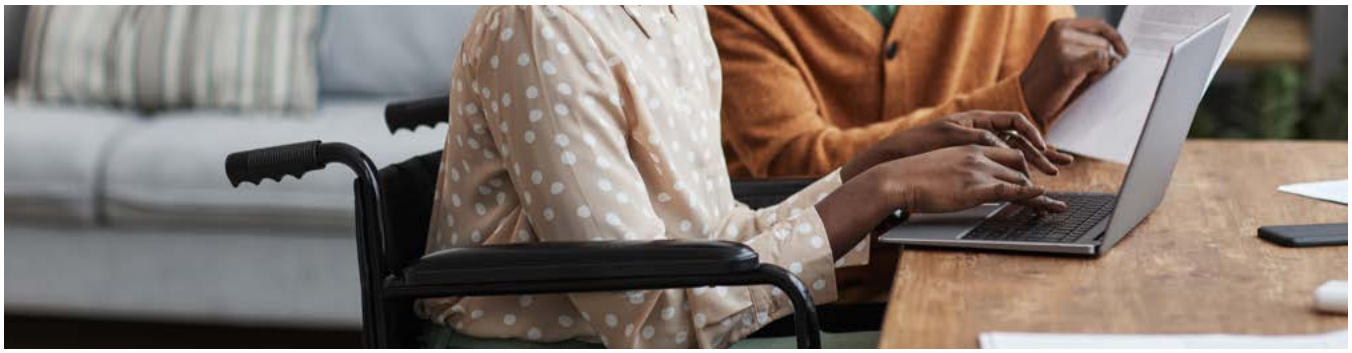
Employee Paid; Rate based on age. Contact Call Center or HR for further details

Portability Options for Basic & Voluntary Life

Portability is available when an Insured Person's employment terminates for a reason other than sickness or injury or retirement at the Social Security Normal Retirement Age (SSNRA). The Insured Person's coverage must be enforce for at least 12 months in a row just prior to the date employment ends.

This person has the option to continue all or part of his or her insurance enforce when employment ends without Evidence of Insurability. To continue insurance, application and the first premium payment must be made within the time period specified in the policy. Coverage can continue until the earlier of the date the master policy terminates or up to 36 Months.

For information on Portability, please contact Human Resources.



Disability Insurance

Short-Term Disability

To ensure your income will continue if you are unable to work due to a non-occupational disability that extends for more than 7 consecutive days, Kreider Farms provides short-term disability (STD) coverage through the Lincoln Financial Group. Benefits are payable for a non-occupational injury or illness that keep you from performing the normal duties of your job.

Benefits Start After: 7 day accident & illness waiting period

Benefit Amount: 60% of earnings up to $2,500 / week

Benefit Duration: 25 weeks

"Pre-existing Condition Limitation: 3/6

Long-Term Disability

Long-Term Disability (LTD) insurance helps replace a portion of your income if you are disabled for an extended period of time. Eligibility for long-term benefits are generally defined as, due to sickness or accidental injury which you are receiving appropriate care and treatment; are complying with your treatment requirements and unable to earn more than 80% of your predisability earnings. Kreider Farms provides long-term disability (LTD) coverage through the Lincoln Financial Group.

Benefits Start After: 180 days

Benefit Amount: 60% of predisability monthly earnings

Maximum Benefit: $6,000 / month

Benefit Duration: The later of your SSNRA* or the Maximum Benefit Period.

**Pre-existing Condition Limitation: 3/12*

***SSNRA means the Social Security Normal Retirement Age in effect under the Social Security Act on the Policy Effective Date.*

Employee Paid; Rate based on age. Contact Call Center or HR for further details

Pre-Existing Condition Limitations

Lincoln Financial Group will not pay benefits for any period of Disability caused or contributed to by, or resulting from, a Pre-existing Condition. A "Pre-existing Condition" means any Injury or Sickness for which you incurred expenses, received medical treatment, care or services including diagnostic measures, took prescribed drugs or medicines, or for which a reasonable person would have consulted a Physician within 3 months before your most recent effective date of insurance.

The Pre-existing Condition Limitation will apply to any added benefits or increases in benefits. This limitation will not apply to a period of Disability that begins after you are covered for at least 6 months for short-term disability or 12 months for long-term disability after your most recent effective date of insurance, or the effective date of any added or increased benefits.

PCS Retirement®

401(k) Retirement Account

The Kreider Farms 401(k) Retirement Savings Plan offers a convenient way to save for your future through payroll deductions. Kreider Farms will match 50% of the first 6% of your contributions to the plan.

Eligibility

You are eligible to participate in the plan as of the first day of the month following 60 days of employment with Kreider Farms.

Change your contribution at any time online at www.pcsretirement.com or you may call 1-888-621-5491.

Employee Contributions

Contributions from your pay are made on a pre or post tax basis up to the IRS annual limit. If you are 50 years of age or older (or if you will reach age 50 by the end of the year), you may make a catch-up contribution in addition to the normal IRS annual limit.

Vesting

Vesting refers to your right of ownership to the employer money in your account. The vesting schedule is as follows:

- 25% after one year of service
- 50% after two years of service
- 75% after three years of service
- 100% after four years of service.

Additional Features

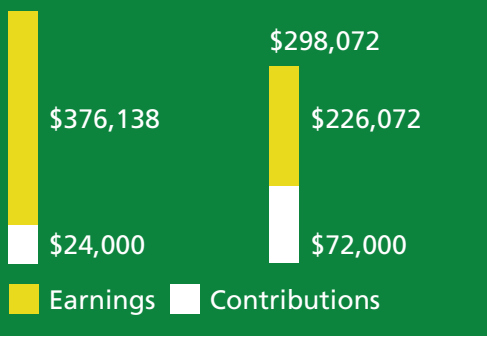
- **A broad range of investment options.** In deciding how to allocate the investment of your account balance, keep in mind that some of the plan's investment options, known as "target date funds," contain an asset allocation strategy within the investment option itself.
- **Automatic contributions.** If you want to have contributions automatically deducted, Kreider Farms' plan offers automatic enrollment.
- **An account you can take with you.** Should you leave the company, your vested balance is yours to take with you.

Watch a brief video explaining 401(k) retirement plans.

Starting earlier can pay off

It's important to save enough for your future, and it's also important to understand the concept of compounded returns. The chart shows how starting earlier puts compounding to work for you over time.

Save $200 a month:



This hypothetical illustration assumes pre-tax contributions made at the beginning of each month and an annual effective rate of return of 8% and reinvestment of earnings.

**Start now assumes the contributions are invested for 40 years;*

***Wait 10 years assumes contributions are invested for 30 years. Results are for illustrative purposes only and are not meant to represent the past or future performance of any specific investment vehicle.*

Voluntary Benefits

The following Voluntary Benefits can complement existing medical coverage and help fill financial gaps caused by out-of-pocket expenses such as deductibles, co-payments, and non-covered medical services. Benefits are paid regardless of what is covered by medical insurance. Payments are made directly to you, to spend as you choose.

All three plans are portable (you can continue coverage if you leave the company) and each plan includes a wellness benefit of $50.

Accident Insurance

Accident Insurance is designed to help covered individuals meet the out-of-pocket expenses and extra bills that can follow an accidental injury, whether minor or catastrophic. Lump sum benefits are paid directly to you based on the amount of coverage listed in the schedule of benefits. The coverage is guaranteed issue so no health questions are required.

Below are some examples of covered accidents and the Benefit Amount that you will be paid:

Basic Accidental Death:
$50,000
Dislocated Hip:
$3,500
Fractured Fingers:
$300
Fractured Ankle:
$1,750
Fractured Rib: $800
Dislocated Wrist: $1,475
Major Diagnostic: $300
Initial Hospitalization:
$1,000

Accident Insurance Biweekly Cost	
EE Only	$6.23
EE + Spouse	$9.12
EE + Child(ren)	$11.19
Family	$15.00

Critical Illness Insurance

Critical Illness Insurance is designed to help you offset the financial effects of a catastrophic illness with a lump sum benefit if you are diagnosed with a covered critical illness. The benefit is based on the amount of coverage in effect on the date of diagnosis or the date treatment is received according to the terms and provisions of the policy.

You have the choice of electing coverage of $10,000 or $20,000.

Both amounts are Guaranteed Issue coverage. Your Spouse/Domestic Partner will be offered 50% and child(ren) will be offered 50% of your benefit amount.

Below are some examples of covered critical illnesses and the Benefit Amount (BA) that you will be paid:

Alzheimer's Disease:
Initial Benefit: 100% of BA
Major Organ Failure:
Initial Benefit: 100% of BA
Invasive Cancer:
Initial Benefit: 100% of BA
Stroke:
Initial Benefit: 100% of BA
Heart Attack:
Initial Benefit: 100% of BA

Employee Paid; Rate based on age. Contact Call Center or HR for further details

Hospital Indemnity Ins.

Hospital Indemnity Insurance is designed to help provide financial protection by paying a benefit due to a hospitalization and, in some cases, for treatment received for an accident or sickness, even if that treatment occurs outside the hospital. You may use the benefit to meet the out-of-pocket expenses and extra bills that occur.

Below are some examples of covered incidents and the Benefit Amount that you will be paid:

Admission Benefit:
(limited to two times per calendar year)
$1,000
ICU Supplemental Benefit:
(in addition to Admission, limited to one time per calendar year)
$2,000
Confinement Benefit:
(limited to 30 days per calendar year)
$200
ICU Supplemental Benefit:
(in addition to Confinement, limited to 30 days per calendar year)
$400

Hospital Indemnity Biweekly Cost	
EE Only	$11.61
EE + Spouse	$24.73
EE + Child(ren)	$17.63
Family	$32.08

For a full list of coverages for each plan and specific benefit information, please refer to the applicable insurance contract.

Renalogic
Guaranteed Impact. Every Day.

ImpactAdvocate

Your employer has partnered with Renalogic to provide ImpactAdvocate; a comprehensive member advocacy program. ImpactAdvocate is designed to support plan members with late-stage chronic kidney disease (CKD) and/or end-stage renal disease (ESRD). This program is FREE and your participation is 100% confidential.

What Does ImpactAdvocate Offer?

1. **Provider Options:** We provide coordination of care with in-network providers, helping members find transplant centers, nephrologists and other specialty physicians.
2. **Medicare Education:** We offer education and assistance with enrolling qualifying members into Medicare part-A and part-B, ensuring they have access to the necessary coverage for their treatment. Members with ESRD qualify for Medicare coverage regardless of their age.
3. **Billing Education:** We help provide balance billing education and assistance to members who receive a bill from their dialysis provider, ensuring they understand their financial responsibilities and have access to additional coverage or financial assistance.
4. **Transportation Coordination:** We assist in coordinating transportation to and from dialysis treatments and transplant appointments, making it easier for members to access the care they need.
5. **Treatment Option Review:** We help members select the dialysis modality that best aligns with their lifestyle and clinical needs. This includes support with dialysis preparation and access placement for the modality of your choice.
6. **Transplant Readiness:** We assist plan members in preparing for kidney transplant surgery. This includes educating members on the requirements and steps involved in the process, how to get listed on the transplant waitlist, and ensuring you stay active on the waitlist.

Our goal is to help plan members dealing with chronic conditions navigate the challenging healthcare landscape, understand their clinical and coverage options, and provide guidance throughout their treatment journey. With the help of Renalogic Nurse Advocates, we aim to improve your health care.

To get started with this FREE employer-sponsored program, please visit
Renalogic.com/Enroll-For-Free/

Email: MemberServices@Renalogic.com

Call 1-833-998-3750

Glossary of Terms

Watch a brief video reviewing key benefit-related terms.

This glossary has many commonly used terms, but it isn't a full list. These are not contract terms. Those can be found in your insurance policy or certificate.

Allowed Amount: Maximum amount on which payment is based for covered health care services. This may be called "eligible expense," "payment allowance" or "negotiated rate." If your provider charges more than the allowed amount, you may have to pay the difference. (See Balance Billing.)

Balance Billing: When a provider bills you for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. A preferred provider may not balance bill you.

Co-insurance: Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service. You pay co-insurance plus any deductibles you owe. For example, if the health insurance or plan's allowed amount for an office visit is $100 and you've met your deductible, your co-insurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount. (Jane pays 20%, her plan pays 80%.)

Co-payment: A fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

Deductible: The amount you owe for health care services your health insurance or plan covers before your health insurance or plan begins to pay. For example, if your deductible is $1000, your plan won't pay anything until you've met your $1000 deductible for covered health care services subject to the deductible. The deductible may not apply to all services. (Jane pays 100%, her plan pays 0%.)

Emergency Room Care: Emergency services received in an emergency room.

Emergency Services: Evaluation of an emergency medical condition and treatment to keep the condition from getting worse.

Home Health Care: Health care services a person receives at home.

Hospitalization: Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be outpatient care.

Medically Necessary: Health care services or supplies needed to prevent, diagnose or treat an illness, injury, disease or its symptoms and that meet accepted standards of medicine.

Network: The facilities, providers and suppliers your health insurer or plan has contracted with to provide health care services.

Non-Preferred Provider: A provider who doesn't have a contract with your health insurer or plan to provide services to you. You'll pay more to see a non-preferred provider. Check your policy to see if you can go to all providers who have contracted with your health insurance or plan, or if your health insurance or plan has a "tiered" network and you must pay extra to see some providers.

Out-of-Pocket Limit: The most you pay during policy period (usually a year) before your health insurance or plan begins to pay 100% of the allowed amount. This limit never includes your premium, balance-billed charges or health care your health insurance or plan doesn't cover. Some health insurance or plans don't count all of your co-payments, deductibles, co-insurance payments, out-of-network payments or other expenses toward this limit. (Jane pays 0%, her plan pays 100%.)

Preauthorization: A decision by your health insurer or plan that a health care service, treatment plan, prescription drug or durable medical equipment is medically necessary. Sometimes called prior authorization, prior approval or precertification. Your health insurance or plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise your health insurance or plan will cover the cost.

Preferred Provider: A provider who has a contract with your health insurer or plan to provide services to you at a discount. Check your policy to see if you can see all preferred providers or if your health insurance or plan has a "tiered" network and you must pay extra to see some providers. Your health insurance or plan may have preferred providers who are also "participating" providers. Participating providers also contract with your health insurer or plan, but the discount may not be as great, and you may have to pay more.

Primary Care Provider: A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law, who provides, coordinates or helps a patient access a range of health care services.

UCR (Usual, Customary and Reasonable): The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.

Urgent Care: Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

Annual Notices

Health Insurance Portability and Accountability Act (HIPAA)

For purposes of the health benefits offered under the Plan, the Plan uses and discloses health information about you and any covered dependents only as needed to administer the Plan. To protect the privacy of health information, access to your health information is limited to such purposes. The health plan options offered under the Plan will comply with the applicable health information privacy requirements of federal regulations issued by the Department of Health and Human Services. The Plan's privacy policies are described in more detail in the Plan's Notice of Health Information Privacy Practices or Privacy Notice. Plan participants in the Company-sponsored health and welfare benefit plan are reminded that the Company's Notice of Privacy Practices may be obtained by submitting a written request to the Human Resources Department. For any insured health coverage, the insurance issuer is responsible for providing its own Privacy Notice, so you should contact the insurer if you need a copy of the insurer's Privacy Notice.

Newborns' and Mothers' Health Protection Act

Group health plans and health issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours if applicable).

Notice Regarding Special Enrollment

If you are waiving enrollment in the Medical plan for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in the Medical plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

States with Individual Mandate

Taxpayers in CA, DC, MA, NJ, RI, and VT (this list is neither complete nor exhaustive) are reminded that your state imposes an individual mandate penalty (tax) should you, your spouse, and children choose to not have (and keep) medical/rx coverage for each tax year. Please consult your tax advisor for how a non-election for health coverage may affect your tax situation.

Special Enrollment Rights CHIPRA – Children's Health Insurance Plan

You and your dependents who are eligible for coverage, but who have not enrolled, have the right to elect coverage during the plan year under two circumstances:

- You or your dependent's state Medicaid or CHIP (Children's Health Insurance Program) coverage terminated because you ceased to be eligible.
- You become eligible for a CHIP premium assistance subsidy under state Medicaid or CHIP (Children's Health Insurance Program).

You must request special enrollment within 60 days of the loss of coverage and/or within 60 days of when eligibility is determined for the premium subsidy.

Genetic Nondiscrimination

The Genetic Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting, or requiring, genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, the Company asks Employees not to provide any genetic information when providing or responding to a request for medical information. Genetic information, as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Qualified Medical Child Support Order

QMCSO is a medical child support order issued under State law that creates or recognizes the existence of an "alternate recipient's" right to receive benefits for which a participant or beneficiary is eligible under a group health plan. An "alternate recipient" is any child of a participant (including a child adopted by or placed for adoption with a participant in a group health plan) who is recognized under a medical child support order as having a right to enrollment under a group health plan with respect to such participant. Upon receipt, the administrator of a group health plan is required to determine, within a reasonable period of time, whether a medical child support order is qualified, and to administer benefits in accordance with the applicable terms of each order that is qualified. In the event you are served with a notice to provide medical coverage for a dependent child as the result of a legal determination, you may obtain information from your employer on the rules for seeking to enact such coverage. These rules are provided at no cost to you and may be requested from your employer at any time.

Annual Notices *continued...*

Notice of Required Coverage Following Mastectomies

In compliance with the Women's Health and Cancer Rights Act of 1998, the plan provides the following benefits to all participants who elect breast reconstruction in connection with a mastectomy, to the extent that the benefits otherwise meet the requirements for coverage under the plan:

- reconstruction of the breast on which the mastectomy has been performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- coverage for prostheses and physical complications of all stages of the mastectomy, including lymphedemas. The benefits shall be provided in a manner determined in consultation with the attending physician and the patient. Plan terms such as deductibles or coinsurance apply to these benefits.

Women's Preventive Health Benefits

The following women's health services are considered preventive. These services generally will be covered at no cost share, when provided in network:

- Well-woman visits (annually and now including prenatal visits)
- Screening for gestational diabetes
- Human papilloma virus (HPV) DNA testing
- Counseling for sexually transmitted infections
- Counseling and screening for human immunodeficiency virus (HIV)
- Screening and counseling for interpersonal and domestic violence
- Breast-feeding support, supplies and counseling
- Generic formulary contraceptives are covered without member cost-share (for example, no copayment). Certain religious organizations or religious employers may be exempt from offering contraceptive services.

Uniformed Services Employment and Reemployment Rights Act (USERRA)

If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents (including spouse) for up to 24 months while in the military. Even if you do not elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions for pre-existing conditions except for service-connected injuries or illnesses.

Mental Health Parity and Addiction Equity Act of 2008

This act expands the mental health parity requirements in the Employee Retirement Income Security Act, the Internal Revenue Code and the Public Health Services Act by imposing new mandates on group health plans that provide both medical and surgical benefits and mental health or substance abuse disorder benefits. Among the new requirements, such plans (or the health insurance coverage offered in connection with such plans) must ensure that: the financial requirements applicable to mental health or substance abuse disorder benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the plan (or coverage), and there are no separate cost sharing requirements that are applicable only with respect to mental health or substance abuse disorder benefits.

Notice to Covered Members

The plans you have selected through your employer-provided employee benefits program are insured by the carrier listed on the confirmation statement or are self-funded plans and the listed carriers is the Plan's claims payer. Administrative services for the billing and collection of premiums from your plan sponsor for the insurance coverages are provided by AP Benefit Advisors, LLC, a licensed Third Party Administrator, pursuant to the agreement previously entered into by AP Benefit Advisors, LLC and the insurer/claims payer. The insurer/claims payer is responsible for eligibility and benefit determination, payment of claims, and all other services associated with your coverage.

Important Notice from Kreider Farms About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Kreider Farms and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. Kreider Farms has determined that the prescription drug coverage offered by Kreider Farms' Employee Benefits Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens to Your Current Coverage If You Decide to Join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Kreider Farms coverage will not be affected. Details of the Plan's prescription drug benefits are included in the separate benefits booklet previously provided to you as part of (or along with) the Plan's Summary Plan Description. In addition, keep in mind that your current coverage pays for other health expenses for you and, if applicable, your eligible dependents, in addition to prescription drugs, and you will still be eligible to receive all of your current health and prescription drug benefits even if you choose to enroll in a Medicare prescription drug plan. If you are enrolled in both the Plan and a Medicare prescription drug plan, your prescription coverage under the Plan will be coordinated with the Medicare prescription drug benefit.

If you do decide to join a Medicare drug plan and drop your current Kreider Farms coverage, be aware that you and your dependents may not be able to get this coverage back.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Kreider Farms and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

For More Information about this Notice or Your Current Prescription Drug Coverage

Contact the person or office listed below for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through The Company changes. You also may request a copy of this notice at any time.

For More Information about Your Options under Medicare Prescription Drug Coverage

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1 800 MEDICARE (1 800 633 4227). TTY users should call 1 877 486 2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1 800 772 1213 (TTY 1 800 325 0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and whether or not you are required to pay a higher premium (a penalty).

Date: **January 1st, 2026**

Name of Entity/Sender: **Noah W. Kreider & Sons, LLP**

Contact Position/Office: **Human Resources**

Address: **1461 Lancaster Road, Manheim, PA 17545**

Phone Number: **1-717-665-4415**

COBRA

Under the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, COBRA qualified beneficiaries (QBs) generally are eligible for group coverage during a maximum of 18 months for qualifying events due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

COBRA coverage is not extended for those terminated for gross misconduct. Upon termination, or other COBRA qualifying event, the former employee and any other QBs will receive COBRA enrollment information.

Qualifying events for employees include voluntary/involuntary termination of employment and the reduction in the number of hours of employment. Qualifying events for spouses or dependent children include those events above, plus, the covered employee becoming entitled to Medicare; divorce or legal separation of the covered employee; death of the covered employee; and the loss of dependent status under the plan rules.

If a QB chooses to continue group benefits under COBRA, they must complete an enrollment form and return it to the Plan Administrator with the appropriate premium due. Upon receipt of premium payment and enrollment form, the coverage will be reinstated. Thereafter, premiums are due on the 1st of the month. If premium payments are not received in a timely manner, Federal law stipulates that your coverage will be canceled after a 30-day grace period. If you have any questions about COBRA or the Plan, please contact the Plan Administrator.

Please note, if the terms of the Plan and any response you receive from the Plan Administrator's representatives conflict, the Plan document will control.

Health Insurance Marketplace

The Patient Protection Affordability Care Act ("PPACA") was signed into law on March 23, 2010. Under PPACA, individuals are required to have creditable health insurance coverage or pay a penalty (if applicable) to the Internal Revenue Service. This is known as the Individual Mandate. For more information on the details of PPACA please visit https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/affordable-care-act/for-workers-and-families.

PPACA created a new way to buy health insurance which is called the Health Insurance Marketplace ("Marketplace"), also known as Exchanges. These Marketplaces are established by each individual state, the federal government or as a partnership between the state and the federal government. Through the Marketplaces, individuals can compare and purchase coverage (with a possible premium subsidy for those qualifying as low income; subsidies are made available as a federal tax credit through the Marketplace for individuals that are not eligible for coverage through their employer.

If you are enrolled in Kreider Farms' medical plan, then PPACA may have little effect on you. Kreider Farms' medical plans meet or exceed the minimum coverage requirements set by PPACA. If you are eligible for our plans, you will not be eligible for federal tax credits. You still have the option to visit the Marketplace to see the coverage options available. If you purchase a health plan through the Marketplace instead of purchasing health coverage offered by Kreider Farms, you will lose any contribution your employer makes for your health coverage, and your payments for coverage through the Marketplace will be made on an after-tax basis. (See https://www.healthcare.gov/have-job-based-coverage/).

If you are not eligible to enroll in Kreider Farms' medical plan, you may have a few options to purchase medical coverage. These options, if applicable, may include but are not limited to: your spouse's medical plan, your parent's medical insurance plan (if you are under age 26), or from several insurance companies offered through the Marketplace. If you shop for coverage through the Marketplace, you may be eligible for a federal tax credit and/or subsidy if you qualify as low income. (See also: healthcare.gov).

How Can I Get More Information?

For more information about purchasing medical coverage through the Marketplace please visit healthcare.gov or call 1-800-318-2596.

Human Resources: 1-717-665-8256 genisee.carranza@kreiderfarms.com